

AKI Nursing Care Plan

Patient Information

- Full Name: _____
- Date of Birth: ____ / ____ / _____
- Gender: _____
- Patient ID: _____
- Contact Number: _____
- Email Address: _____

Assessment

Assessment	Observations	Notes/Referral
Physical Signs	<input type="checkbox"/> Reduced urine output <input type="checkbox"/> Swelling in hands, feet, or face <input type="checkbox"/> Fatigue	
Gastrointestinal Symptoms	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Abdominal pain	
Neurological Signs	<input type="checkbox"/> Confusion <input type="checkbox"/> Altered mental status	
Cardiovascular Manifestations	<input type="checkbox"/> Elevated blood pressure <input type="checkbox"/> Irregular heart rhythm <input type="checkbox"/> Palpitations <input type="checkbox"/> Signs of fluid overload	
Renal Factors		

Metabolic Effects	<input type="checkbox"/> Acidosis <input type="checkbox"/> Protein catabolism	
Secondary Issues		

Interventions

Area of Management	Interventions / Rationale	Notes/Referral
Fluid Management		
Electrolyte Management		
Medication Management		
Nutritional Support		
Vital Signs Monitoring		

Education and Support	
Prevention of Complications	

Physician's Notes and Recommendations

Physician's Signature: _____ **Date:** ____ / ____ / _____